AGENDA ITEM 5
AUDIT RESOLUTION STATUS– HEALTH PLAN AUDITS
(PRIOR YEAR REPORTS WITH CURRENT YEAR UPDATES)
AS OF DECEMBER 31, 2008

Name of Auditee (Report Issue Date)	Summary of Findings	Status/Comments
Third Party Administration of Long Term Care Program (Long Term Care Group) (9/24/04)	2. The Long Term Care Group should convert to the new Financial Management System.	COMPLETE. This issue still exists and was noted in the August 2008 Review of the Long Term Care Group. This finding will continue to be addressed until fully resolved under that review.
Review of Blue Cross of California (July 30, 2007)	8.1 Blue Cross has not achieved Utilization Review Accreditation Commission Accreditation as required.	IN PROGRESS. Desktop submission/application for Utilization Review Accreditation Commission will be up and running in early calendar 2009. The process will ensue soon after desktop submission. Follow-up with Blue Cross contact will be conducted at the end of March 2009.
Review of California Association of Highway Patrolmen Medical Plan (3/12/08)	4.1 The underlying data for claims turnaround and accuracy and telephone responsiveness is maintained for only 11 months and was not available for review during our audit.	COMPLETE. At receipt of the final report, California Association of Highway Patrolmen (CAHP) had initiated the appropriate steps to resolve this issue. CAHP agrees to work with Blue Cross of California to ensure that the necessary data in support of the statistics be retained for three years, as required in the contract between CalPERS and CAHP.
	5.1 In the first quarter, the telephone wait time exceeded the minimum performance standard. Blue Cross of California compensated CAHP for failure to meet performance levels, but the compensation was late and the amount short. We recommend CAHP monitor the timely and accurate receipt of quarterly service performance compensation.	COMPLETE. At receipt of the final report, CAHP had developed a tracking system to ensure follow up and receipt of accurate performance guarantee compensation, as required per the contract between CAHP and Blue Cross of California.

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Review of Blue Cross Claims Review (Wolcott) (4/2/08)	4.1 Wolcott identified an out-of-network claim for mental health services. The claim indicated valid CPT codes and indicated the type of therapy that was provided (rolfing, art therapy, private yoga instruction, family and group family therapy, and substance abuse counseling). However, the CPT codes indicated did not match the type of therapy that was rendered to the patient. Family and group family counseling is specifically excluded in the plan booklet, which is typical. Rolfing, art therapy, private yoga instruction are types of therapy that are not covered by any plan sponsor with which we are familiar.	IN PROGRESS. The case has been sent to the Risk Management Department for review and to initiate corrective adjustment (overpayment recovery). Health Benefits Branch will follow up for a March 2009 update.
	6.1 Wolcott identified three claims for services performed by an acupuncturist. All three claims were out-of-network. The CalPERS benefit booklet indicates that out-of-network services provided by an acupuncturist should be reimbursed at a 60% benefit level. However, these claims were reimbursed at the in-network 80% benefit level. Blue Cross indicated to Wolcott that since there is an incomplete network of acupuncturists, they do not want to penalize the member.	IN PROGRESS. Blue Cross of California Account and Claims Management will schedule a meeting with CalPERS to discuss this issue.
	7.1 Wolcott requested accident information for a patient receiving treatment for carpal tunnel, in order to establish that treatments were not work related. Blue Cross indicated that a letter had been sent to the member a week prior to the audit. When Wolcott inquired as to reason for the delay, Blue Cross indicated that Meridian (outsource vendor) discovered that diagnosis codes with four digits were not being identified as requiring investigation. As a result, letters for these claims were generated in January 2008.	IN PROGRESS. Blue Cross of California and CalPERS Office of Health Plan Administration plan to discuss further in a March 2009 update meeting.

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Review of Blue Cross Claims Review (Wolcott) (4/2/08) (*continued*)	8.1 Wolcott identified a large claim (in excess of $100,000) where the initial processing of the claim applied the agreed upon per diem rates. However, the contract with this hospital indicates that if the claim exceeds $65,000, then stop-loss pricing should apply. The contract also states that the hospital must send in this claim requesting stop-loss pricing rules be applied. Therefore, the hospital sent in a second submission requesting the stop-loss pricing and Blue Cross correctly adjusted the claim to reflect the stop-loss pricing and generated the additional payment. This is an inefficient process. In addition, in reprocessing of this claim, in order to adjust for the stop-loss provision, the additional $857.70 that would have satisfied the member's out-of-pocket amount was not applied and was CalPERS' responsibility.	IN PROGRESS. Blue Cross maintains its procedures are correctly followed; however, CalPERS and Blue Cross plan to further discuss this issue, in order to come to an agreement on how to handle in the future.
	9.1 Wolcott identified a claim with a diagnosis that is included in the DSM-IV list. This list is utilized by Blue Cross, as directed by CalPERS Evidence of Coverage, in order to identify mental/nervous disorders that should not have the mental health maximums applied.	IN PROGRESS. Blue Cross maintains the claim in question was properly reimbursed as nervous and mental. CalPERS and Blue Cross plan to further discuss this issue, in order to come to an agreement on how to handle in the future.
	11.1 Wolcott identified a claim with a new patient exam code. This code cannot be billed by the provider unless it has been more than three years since it has seen the patient. Blue Cross indicated it would be a manual process to deny a claim for new patient that was less than three years since the last visit.	COMPLETE. Until such time as the system can be enhanced, processors will have to review the history to ensure new patient exams are administered per the rules. Wolcott will review this issue again in future audit projects.